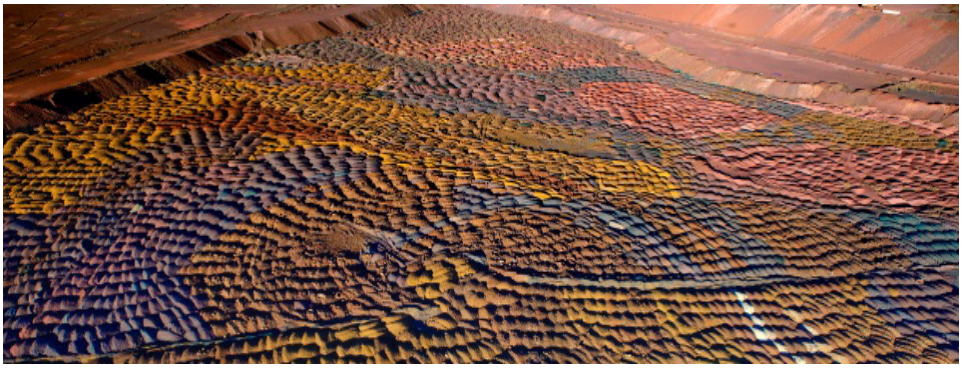
Critical Illness Insurance

CHUBB®



Provincial plans do not take care of all that is needed when you are diagnosed with a critical condition. At a time when incomes are potentially reduced, and expenses increase due to medical needs, a critical illness plan is the best way to fund a possible lengthy recovery period. As a member of the IATSE 891 Benefits of Film* with coverage on the active Hour Bank, you are provided with a $25,000 Critical Illness benefit to help you in your recovery

Did You Know?

- Approximately 196,900 new cases of cancer occurred in Canada in 2015[1].
- 63% of Canadians diagnosed with cancer will survive at least 5 years after their diagnosis[1].
- There are an estimated 70,000 heart attacks each year in Canada. That's one heart attack every 7 minutes[2].
- Up to 40,000 cardiac arrests occur each year in Canada. That's one cardiac arrest every 12 minutes[2].
- There are estimated 50,000 strokes in Canada each year. That's one stroke every 10 minutes[2].

The Benefits

Chubb Life Insurance Company of Canada's ("Chubb Life") Critical Illness program provides the kind of financial assistance that allows you to focus on the important things during recovery like getting better. This benefit provides a lump sum pay-out following the diagnosis of a covered condition[3], which can be used any way you wish.

Covered Conditions

- Alzheimer's Disease
- Aorta Surgery
- Benign Brain Tumour
- Blindness
- Cancer
- Cancer Recurrence
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dismemberment
- Heart Attack
- Heart Valve Replacement
- Loss of Independence
- Loss of Speech
- Major Organ Failure
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke

These additional benefits[4] are also included:

- Ductal Carcinoma in Situ (early stage breast cancer)
- Early Stage Prostate Cancer Treatment
- Hip and Knee Replacement
- 2nd Event Coverage

Frequently Asked Questions

What if I've been diagnosed with one of the listed covered conditions already?

Chubb Life will not pay the benefit amount for any insured condition you were diagnosed with before the effective date of the policy.

Are there other limitations to the policy I should be aware of?

Chubb Life will not pay any benefit amount for cancer, early state prostate cancer treatment or DCIS for a period of 90 days from the effective date, or the latest reinstatement date of the policy.

What if I make a full recovery?

We want you to make a full recovery. That is the purpose of critical illness insurance. It provides you with the funds to assist you during recovery so that your finances will also survive your critical condition.

What if I don't survive?

You must survive 30 days (180 days for paralysis). After that, if you are eligible for a claim payment but do not survive to receive it, we will make the payment to your beneficiary.

I have disability coverage, so why would I need critical illness coverage also?

Disability coverage is meant to provide you with a percentage of your income in the event you are unable to work. At a time when your income may be reduced due to being on disability, you are likely to see an increase in expenses for medical treatment. Critical illness coverage helps fill this gap.

Also, you are not required to be unable to work in order to receive your critical illness benefit. It is paid in addition to your income or disability benefits.

How does an insurance company decide if my critical illness is eligible for a benefit payment?

The covered conditions are defined by medical terms, if you have been diagnosed by a physician, specializing in the field of your illness, your doctor will provide the appropriate medical evidence required that determines if your condition falls within the policy terms.

What are the benefit amounts for the additional benefits?

The Second Event benefit is paid at 100% of the principal sum insured. Each of the other additional benefits is paid at 20% of the principal sum insured. Additional benefits are not deemed to be Insured Conditions, nor do they fall under the category of Insured Conditions for the purposes of the Second Event Benefit. Partial payment for one of the additional benefits does not reduce eligible payment of a principal sum payment. Each Partial Payment Benefit is payable only once.

Contact Us

If you have any questions regarding this coverage please see your employee benefits booklet for details, or contact the following:

J&D Benefits Inc.
8901 Woodbine Avenue, Suite 228,
Markham, ON L3R 9Y4

Telephone: 905·477·7088 or
Toll Free: 1·800·218·7018
Fax: 905·477·2249
Email: benefitsoffilm@jdbenefits.com

BENEFITS OF FILM
IATSE 891 | ACTIVE HEALTH PLAN

Chubb. Insured.℠

* IATSE 891 Benefits of Film is under Group Policy Number CI50081101 with the Motion Picture Workers Health Benefits Trust.

[1.] Canadian Cancer Society. [2.] Heart and Stroke Foundation. [3.] A single sum benefit is paid upon diagnosis of one of the listed covered illness for the first time in your lifetime, or injury, and survival after 30 days (180 days survival for Paralysis, and a 90 day waiting period for Cancer applies). [4.]All additional benefits paid at a percentage of the lump sum benefit.

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CRITICAL ILLNESS BENEFIT
CLAIMANT'S STATEMENT

Please return to: J&D Benefits Inc.
228-8901 Woodbine Avenue
Markham, ON L3R 9Y4
Telephone: 905-477-7088 1-800-218-7018

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Policy No.: CI50081101		
Name:		
Phone #: ( )		
Address:		
City:	**Province:**	**Postal Code:**
Sex: ☐ **Male** ☐ **Female**	**Date of Birth:**	
Health Insurance #:		

CLAIM INFORMATION

Please describe the nature and extend of your Critical Illness:		
On what date was it diagnosed?		
If applicable, on what date was surgery performed?		
On what date did symptoms first commence?		
Please describe these symptoms:		
On what date did you first consult a medical practitioner in connection with your illness?		
Name of Physician:	**Phone #: ( )**	
Address:		
City:	**Province:**	**Postal Code:**
Have you undergone any tests or investigations related to this diagnosis? ☐ **Yes** ☐ **No**		
If yes, please provide details and dates.		
Have you submitted a previous Critical Illness claim at any time with any insurer? ☐ **Yes** ☐ **No**		
If yes, please provide details and dates.		

MEDICAL CONSULATIONS			
Name of your Personal Physician:			
Phone #: ( )			
Address:			
City:		**Province:**	**Postal Code:**
Please provide details of any other doctors or specialists who have been consulted in connection with your illness:			
Name:		**Phone #: ( )**	
Address:		**City:**	
Province:	**Postal Code:**	**Date Seen:**	
Name:		**Phone #: ( )**	
Address:		**City:**	
Province:	**Postal Code:**	**Date Seen:**	
Name:		**Phone #: ( )**	
Address:		**City:**	
Province:	**Postal Code:**	**Date Seen:**	
Name:		**Phone #: ( )**	
Address:		**City:**	
Province:	**Postal Code:**	**Date Seen:**	
If you have been treated at a hospital or similar institution, please provide the following information:			
Name of Hospital:		**City or Town:**	
Date of Admission:		**Date of Discharge:**	
Name of Hospital:		**City or Town:**	
Date of Admission:		**Date of Discharge:**	
Name of Hospital:		**City or Town:**	
Date of Admission:		**Date of Discharge:**	
Name of Hospital:		**City or Town:**	
Date of Admission:		**Date of Discharge:**	
What other treatments have you received, and are you currently receiving, in connection with your illness? (e.g. medications, therapy, etc.)?			
Type of Treatment:		**Institution:**	
Prescribing Physician:		**Dates:**	
Type of Treatment:		**Institution:**	
Prescribing Physician:		**Dates:**	
Type of Treatment:		**Institution:**	
Prescribing Physician:		**Dates:**	
Type of Treatment:		**Institution:**	
Prescribing Physician:		**Dates:**	

Claimant's Certification: The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered without refund of any premiums paid. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

Privacy Notice: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Chubb Insurance and/or Chubb Life Insurance, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

Authorization: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb Insurance/Chubb Life Insurance, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

Claimant's Name (Please Print): _____

Signature _____ Date _____

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AUTHORIZATION TO OBTAIN INFORMATION (CLAIMANT)

Please return to: J&D Benefits Inc.
228-8901 Woodbine Avenue
Markham, ON L3R 9Y4
Telephone: 905-477-7088 1-800-218-7018

Name of Insured:

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, possessing records or knowledge concerning myself to give to Chubb Insurance or Chubb Life Insurance all such information. I consider such information to be essential to Chubb Insurance or Chubb Life Insurance in complying with its obligations as a provider of benefits.

I am granting this authorization and direction in my capacity as a claimant and concerning my interests or rights in such capacity. Unless, at any earlier time, I withdraw this authorization (notice of which will be provided by Chubb Insurance or Chubb Life Insurance, as applicable; until such notice is received, the authorization shall be deemed to remain in effect), this authorization will remain in effect for so long as Chubb Insurance or Chubb Life Insurance requires and, in any event, for not less than twelve (12) months and for not greater than twenty-four (24) months from the effective date of this authorization, as indicated below. A reproduction of this consent shall be as valid as the original.

Name (Please Print) _____ Signature _____

Dated at _____ of _____
City/Town Region/Municipality

In the Province of _____ on this _____day

of _____.
Month and Year

Signature of Parent/Guardian if Child is a Minor _____

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CRITICAL ILLNESS CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

Please return to: J&D Benefits Inc.
228-8901 Woodbine Avenue
Markham, ON L3R 9Y4
Telephone: 905-477-7088 1-800-218-7018

PATIENT INFORMATION – PLEASE NOTE THAT THE CLAIMANT IS RESPONSIBLE FOR ANY FEE CHARGED FOR THIS INFORMATION

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

IN ORDER TO FACILITATE THE ASSESSMENT OF THIS CLAIM, PLEASE ATTACH ALL HOSPITAL RECORDS, TEST RESULTS, CONSULT NOTES AND SPECIALIST REPORTS APPLICABLE TO THIS CONDITION.

First Name of Patient:	**Last Name of Patient:**	**Date of Birth:**
Diagnosis:		
How long has the insured been your patient?		
Date symptoms first appeared:	**Exact date of diagnosis:**	
Has the patient ever had the same or similar condition? ☐ Yes ☐ No		
If Yes, state when, if applicable, the duration and describe:		
Are there any predisposing risk factors related to the insured's diagnosis? ☐ Yes ☐ No		
Please describe:		
Has the patient undergone surgery/operation/procedure? ☐ Yes ☐ No		
Please provide details:		
Have you attached all hospital records, test results, consult notes and specialist reports applicable to this condition? ☐ Yes ☐ No		
Has the patient been hospitalized? ☐ Yes ☐ No	**Length of Stay: From:**	**To:**
Name of Hospital:		

Physician's Name (please print):	**Specialty:**
Address:	**City:**
Province:	**Postal Code:**
Phone #: ( )	**Fax #: ( )**
Email Address:	

Physician's Signature _____ Date _____